

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 & 14 info. from birth certificate

CERTIFICATE OF DEATH

6/23/61 iwk Reg. Dist. No. 07311

7322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>1 Day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Dighton Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Alfred C</u> <u>Alfred</u> <u>Alfred</u>	4. DATE OF DEATH <u>June 21</u> <u>1961</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 20-1961</u> 9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during and out of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alfred C Ayres, Jr</u>		14. MOTHER'S MAIDEN NAME <u>Queen Ruby Beckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Alelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (Birth wt 1090gms)</u> DUE TO (c) <u>approx 7 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/20</u> , 19 <u>61</u> to <u>6/21</u> , 19 <u>61</u> , that I lost saw the deceased alive on <u>6/21</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C Koles</u> M.D.		ADDRESS (Street, city or town, state) <u>Medinal Center</u> DATE SIGNED <u>6/21/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 23/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne G. Smith</u>		24a. REC'D BY REGISTRAR <u>June 23 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

100001P2 XVI

CERTIFICATE OF DEATH

1933

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7323

07312

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>LOUISE</b> Last <b>BENNETT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14th</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1889</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>71</b> Days <b>14</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>71</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mardela Springs, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Beach</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Bailey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-2665</b>		17. INFORMANT <b>Levador Bennett, Mardela Springs, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>12 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3 June 1961</b> to <b>14 June 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>13 June 1961</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. George Schlesinger</b>				22b. DATE <b>14 June 61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. George Schlesinger</b>	
22d. ADDRESS <b>Mardela Springs, Maryland</b>				22e. REC'D BY REGISTRAR DATE <b>JUN 16 '61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela</b>		23d. LOCATION (City, town, or county) (State) <b>Mardela Springs, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co - Belmar, N.J.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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MEDICAL CERTIFICATION

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7324

CERTIFICATE OF DEATH

Reg. Dist. No.

07313

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL M. Bloodsworth</u>		4. DATE OF DEATH Month Day Year <u>JUNE 21 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29 - 1892</u>
9. AGE (In years lost birth day) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. BLOODSWORTH</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN PALMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-31-2280</u>	
17. INFORMANT <u>Trainer Benson - White Haven Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Pneumonia (dependent)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C.V.A. accident</u> DUE TO <u>chronic Hypertensive C.V. disease</u> (c) <u>chronic Hypertensive C.V. disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 19, 1961</u> , to <u>JUNE 21, 1961</u> , that I last saw the deceased alive on <u>JUNE 21, 1961</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>6/21/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-21-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. W. Hester - Prince Georges</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MEDICAL CERTIFICATION

Figure 1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7325

07314

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 5 Pemberton Rd)</b>		d. STREET ADDRESS <b>R.D.# 5</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>FRANCES</b> Last <b>BOZMAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Dames Quarter, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William David Crockett</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Shores</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. John Wesley Bozman (Husband)</b>		18. ADDRESS <b>R.D.# 5 Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 VENTRICULAR Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Anterior Myocardial infarction</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	20f. (City or town) <b>N/A</b> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1961, to June 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 12, 1961</b> , and that death occurred at <b>7:15 A.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Adkins</b>		22b. DATE SIGNED <b>June 15 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>		22d. ADDRESS <b>Fruitland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jun. 15, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 16 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

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POST OFFICE

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FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7326

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07315

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Berlin</b>			
3. NAME OF DECEASED (Type or print) <b>Carolyn</b>				4. DATE OF DEATH <b>Route # 3</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>A A</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-14-61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>X</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X</b>		9. AGE (In years last birthday) <b>6-3-19 61</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Smith</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Bridell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>772-0</b> DUE TO <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				DATE SIGNED <b>6-5-61</b>			
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-4-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Berlin Maryland</b>	
23. FUNERAL DIRECTOR <b>Thernton B. Jolley, Salisbury, Md</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

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Berlin

Technical General Hospital

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Carolyn

Bridget

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London

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James and John

Demetrius and John

1-2-61

Carl J. Hoyer, M.D.  
1st General Hospital, Berlin

1-1-61

Therese and Henry

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G290 7/5/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. **07316**

7327

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>507 W. College Ave.</b>		d. STREET ADDRESS <b>Park Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Maud</b> Middle <b>I.</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Book Keeping</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Columbia Yingling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Omar J. Groswell Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of intestinal tract</b> <b>153.9</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/18/60</b> , 19____, to <b>6/22/61</b> , 19____, that I last saw the deceased alive on <b>6/20/61</b> , 19____, and that death occurred at <b>7 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>216 Maryland Salisbury, Md.</b> DATE SIGNED <b>6/23/61</b>			
ACTUAL SIGNATURE <b>R C Mitchell</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-26-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin B. Wilson</b>		ADDRESS <b>Princess Anne, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		123 Main St		Heart Disease		Jan 15, 1945		10:00 AM		City of Baltimore		John Doe, M.D.		John Doe, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Examination Date		Last Medical Examination Place		Last Medical Examination Physician		Last Medical Examination Date		Last Medical Examination Place		Last Medical Examination Physician		Last Medical Examination Date		Last Medical Examination Place	
Teacher		Married		None		Jan 10, 1944		City of Baltimore		123 Main St		John Doe, M.D.		Jan 10, 1944		City of Baltimore		John Doe, M.D.		Jan 10, 1944		City of Baltimore	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 15, 1945		10:00 AM		City of Baltimore		John Doe, M.D.		John Doe, Registrar		Jan 15, 1945		10:00 AM		City of Baltimore		John Doe, M.D.		John Doe, Registrar		Jan 15, 1945		10:00 AM	





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FOR STATE  
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07318

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Quantico</b> c. LENGTH OF STAY IN 1b <b>Quantico</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rual (Royal Section)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b> d. STREET ADDRESS <b>Rual (Royal Oak Section)</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lee Culver Byrd</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1904</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR <b>11</b> Months <b>27</b> Days IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D. Quantico, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Greensbury Byrd</b>		14. MOTHER'S MAIDEN NAME <b>Cora E. Dove</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>420-1</b>	
17. INFORMANT <b>Mrs. Frances C. Byrd (Wife)</b> <b>R.D. Quantico, Maryland.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420-1</b> (c) <b>420-1</b> DUE TO (c) <b>420-1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Salisbury, Md. 6-26-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 30, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR <b>Holloway &amp; Co. Salisbury, Maryland.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '61</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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Mr. [Name] (son)

Mr. [Name] (son)

June 28

Mr. [Name] (son)  
Mr. [Name] (son)

Holloway & Co. Salisbury, Wiltshire.  
J. [Name] & Co. Salisbury, Wiltshire.

TO REGISTER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7330

07319

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>86 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HURLOCK</b>		d. STREET ADDRESS <b>--</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DEER'S HEAD STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>H.</b> Last <b>CAMPER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> , Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/1873</b>
9. AGE (In years lost birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Church Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>York Camper</b>		14. MOTHER'S MAIDEN NAME <b>Mary (maiden name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. Rachel Conway Hurlock, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis with hemiplegia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 19 61</b> to <b>June 28, 19 61</b> , that (I) (we) last saw the deceased alive on <b>June 28, 19 61</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Laury</b>		22b. DATE SIGNED <b>6/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Laury</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Salem, Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salem, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son</b> ADDRESS <b>Federalburg, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

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Dr. J. L. Lundy

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07320

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Since 4/25/61</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Bluff State Hospital</b>				d. STREET ADDRESS <b>-</b>			
3. NAME OF DECEASED (Type or print) First <b>Owens</b> Middle <b>-</b> Last <b>Clevenger</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/2/1898</b>		9. AGE (In years lost birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Grasonville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Clevenger</b>				14. MOTHER'S MAIDEN NAME <b>Katy Mansfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-03-3912</b>		17. INFORMANT <b>Records of Pine Bluff State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor. Pulmonale</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Emphysema</b> DUE TO (c) <b>Unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Tuberculosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 25, 19 61</b> to <b>June 12, 19 61</b> , that (I) (we) lost saw the deceased alive on <b>June 12, 19 61</b> , and that death occurred at <b>2:08 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>E. P. Ritchings</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 12, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings, M.D.</b>		22d. ADDRESS <b>Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESTERFIELD</b>		23d. LOCATION (City, town, or county) (State) <b>CENTREVILLE MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Sam</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 7321

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 wk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DECEASED (Type or print) <b>Carol M. Collick</b>		4. DATE OF DEATH Month <b>6</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>AA</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 17 1900</b>	
9. AGE (In years lost birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. GINN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 09 9286</b>	
17. INFORMANT <b>Mrs. Lola Rayne, Berlin, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 4, 1961</b> , to <b>June 11, 1961</b> , that I last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward J. Salvo</b>		ADDRESS (Street, city or town, state) <b>Medical Center Salisbury Del.</b>	
PHYSICIAN'S NAME (Type) <b>Salisbury Del.</b>		DATE SIGNED <b>June 13, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6 12 61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Coolsprings Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Girdletree, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1912



County of Albany  
City of Albany  
I, the undersigned, being a duly qualified Registrar of Deaths for the County of Albany, do hereby certify that on the 12th day of January, 1912, at the City of Albany, New York, died  
James H. Smith, aged 65 years, born at Albany, New York, and residing at Albany, New York, at the time of his death.  
The cause of death was  
Heart Disease.  
Signed at Albany, New York, this 12th day of January, 1912.  
James H. Smith, Registrar of Deaths.

Witness my hand and the seal of the County of Albany, New York, at Albany, New York, this 12th day of January, 1912.

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7333  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07322

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nursing Home - 924 S.Division St</b>				d. STREET ADDRESS <b>Salisbury</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELDRIDGE</b> Middle <b>COLLINS</b> Last <b>COLLINS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>9th</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 25, 1884</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>6</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Jenkins Collins</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>				16. SOCIAL SECURITY NO. <b>Unk</b>			
17. INFORMANT <b>Records:Wicomico County Welfare Office</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1961</b> to <b>June 9, 1961</b> , that (I) <del>met</del> last saw the deceased alive on <b>June 6, 1961</b> , and that death occurred of <b>8:35 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert T. Adkins</b>				22b. DATE <b>June 10 / 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>				22d. ADDRESS <b>Fruitland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>June 20.61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>JUN 22 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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DECLASSIFICATION GUIDE

1983

10

1

General Information  
General Information

John F. Kennedy  
John F. Kennedy

John F. Kennedy  
John F. Kennedy

John F. Kennedy  
John F. Kennedy

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **07323**

7334

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>325 Poplar Hill Ave.</b>				d. STREET ADDRESS <b>325 Poplar Hill Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Arwilla</b> <span style="float: right;">First</span> <b>Conway</b> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> Month <b>6</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>F.M.</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3, 1885</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel Waters</b>	
14. MOTHER'S MAIDEN NAME <b>Leah Jane Dashiell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Marian White, Salisbury, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Regenerative Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>6/14</b> , 19 <b>61</b> , to <b>6/14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/14</b> , 19 <b>61</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. A. Purnell</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>657 W. Main, Salisbury, Md. 15 June 61</b>			
PHYSICIAN'S NAME (Type) <b>E. A. Purnell, M. D. 657 W. Main St. Salisbury, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-18-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>White Haven, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thornton B. Jolley, Salisbury, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

34

MASSACHUSETTS  
STATE BOARD OF HEALTH

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of attending physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of coroner: _____</p>	
<p>10. Signature of health officer: _____</p>	
<p>11. Signature of registrar: _____</p>	
<p>12. Signature of coroner: _____</p>	
<p>13. Signature of health officer: _____</p>	
<p>14. Signature of registrar: _____</p>	
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<p>96. Signature of coroner: _____</p>	
<p>97. Signature of health officer: _____</p>	
<p>98. Signature of registrar: _____</p>	
<p>99. Signature of coroner: _____</p>	
<p>100. Signature of health officer: _____</p>	

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7335  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07324

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>6 hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>THOMPSON</b> Last <b>COOPER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1884</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Framer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Levin Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Twilley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-9481</b>		17. INFORMANT Address <b>Robert E. Cooper, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SENILITY</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> 19 to <b>6-21-61</b> 19, that (I) (we) last saw the deceased alive on <b>6-21-61</b> 19, and that death occurred at <b>8:13</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Andrew C. Mitchell</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. A.C. Mitchell</b>				22d. ADDRESS <b>Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Firemans</b>		23d. LOCATION (City, town, or county) (State) <b>Sharptown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co - Delmar, Del</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>	

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TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CHIEF OF POLICE

NEW YORK

OFFICE

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 2280 6/28/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

07325

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fizuitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>Post Office</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>COTTMAN</u> Last <u>COTTMAN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1881</u> 1880
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simoen Cottman</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Cottman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-16-1428</u>	
17. INFORMANT <u>Paul Cottman</u> Address <u>MARDELLA SPRINGS, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Arteriosclerotic heart disease</u> (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-13</u> , 19 <u>61</u> , to <u>6-13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. A. Purnell</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. A. Purnell, M.D., 657 W. MAIN ST. SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-18-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. CALVARY Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>FIZUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thorenton B. Jolley</u> ADDRESS <u>SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>JUN 23 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christine E. Hume</u>	



7337

CERTIFICATE OF DEATH

Reg. Dist. No.

07326

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>23 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIE LUCAS CROCKETT</u>				4. DATE OF DEATH Month Day Year <u>JUNE 10 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 4, 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>OLIVER J. LUCAS</u>				14. MOTHER'S MAIDEN NAME <u>EMMA W. MATTHEWS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS DOROTHY PATTEY, SALISBURY, MD.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>321X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-18, 1961</u> to <u>6-10, 1961</u> , that I last saw the deceased alive on <u>6-10, 1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. R. Ellis, Jr.</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. R. ELLIS, JR.</u>				DATE SIGNED <u>6-10-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-13-61</u>		22c. NAME OF CEMETERY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>Pocomoke City, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

10050

CERTIFICATE OF DEATH

1931

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information furnished by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information furnished by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7338

CERTIFICATE OF DEATH

Reg. Dist. 07327

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>Accomack</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN: 1b <b>SINCE 5/15/61</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ONLY.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Nursing Home</b>				d. STREET ADDRESS <b>83X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>TANKARD</b> Last <b>CROPPER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 31, 1871</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED CARPENTRY</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN William CROPPER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET WARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>MRS. MARGARET WALKER EXMORE, VA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, ACUTE</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 Wks</b> <b>YRS</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5:30</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/15</b> , 19 <b>61</b> , to <b>6/6</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/1</b> , 19 <b>61</b> , and that death occurred at <b>5:30</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rufus S. Gardner Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Pinebush Road 6/6/61</b>					
PHYSICIAN'S NAME (Type) <b>RUFUS S. GARDNER, JR.</b>		<b>Salisbury, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 8, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EDGE Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Accomack, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Williams</b>				ADDRESS <b>Onancock, VA.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 7 2 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7339

## CERTIFICATE OF DEATH

Reg. Dist. No. 07323

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb <u>1 Hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Zion Church Road RD## 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lemues B. Cropper (Cropper)</u>				4. DATE OF DEATH Month Day Year <u>6 26 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1874</u>	
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Capt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Cropper</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>XX</u>		INFORMANT Address <u>Mrs. Dean Powell Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>442X</u> IMMEDIATE CAUSE <u>Cardiac Decompensation</u> DUE TO <u>Cardio-vascular renal lesions</u> DUE TO <u>Cardio-vascular renal lesions</u> DUE TO <u>Cardio-vascular renal lesions</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-30-61</u> to <u>6-26-61</u> , that I last saw the deceased alive on <u>6-26-61</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>6-26-61</u>							
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D. <u>Salisbury Md</u>					
PHYSICIAN'S NAME (Type) <u>Ph. P. A. Insley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE WHEREOF <u>6/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Ocean View, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Whaley Salisbury, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

M

State of New York  
County of Albany  
City of Albany  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 21st day of January, 1914, at the City of Albany, New York, I attended the deceased, *John A. Smith*, who died at the residence of the deceased, *John A. Smith*, at the age of *45* years, of the disease of *Myocarditis*, the result of *arteriosclerosis*.  
Witness my hand and the seal of my office this 21st day of January, 1914.  
J. A. Smith, M.D.  
City of Albany, New York.

*John A. Smith*  
Myocarditis  
arteriosclerosis  
45 years  
21st day of January, 1914  
City of Albany, New York

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b>				b. COUNTY <b>Accomack</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>MARYLAND</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>								d. STREET ADDRESS <b>83x-3</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Luther Robert Cropper</b>				4. DATE OF DEATH Month Day Year <b>6-18-61</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Laws</b>				14. MOTHER'S MAIDEN NAME <b>Irene E. Broughton</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>227-24-0531</b>				17. INFORMANT <b>Marie Logan New Church, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage: ruptured trachea.</b> 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car ran off road and struck concrete abutment.</b> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:20 P.M. 6-18-61</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route #113</b> 20f. (City or town) <b>Snow Hill</b> (County) <b>Worcester Md.</b> (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D. EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b> 407 Camden Ave. Salisbury, Md. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6-20-61</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>6-24-61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Wattsville Cem.</b> 22d. LOCATION (City, town, or country) <b>Wattsville Va.</b> 23. FUNERAL DIRECTOR <b>Edgar Wharton - New Church, Va.</b> ADDRESS 24a. REC'D BY REGISTRAR <b>DATE 26 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>											

THE STATE  
OF MISSISSIPPI

(M)

Mississippi

Ballabury

Political Journal

Superior

June 2, 1901

Truck Driver

John Jones

Wm. W. W.

General Manager

Get van off road

1:20 A.M.

1:20 A.M.

1:20 A.M.

1:20 A.M.

1:20 A.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

7341  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07330

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>914 Johnson Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hilary</b> Middle <b>Clay</b> Last <b>Dykes</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>77 XXXX 9/10/8X</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>20</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee-Ice Plant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sussex Co. Delaware</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Purnell Dykes</b>		14. MOTHER'S MAIDEN NAME <b>Martha Revell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Arthur J. Dykes</b> <b>914 Johnson St Salisbury, Maryland</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma of prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 5</b> 19 <b>61</b> , to <b>June 30</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>June 30</b> 19 <b>61</b> , and that death occurred at <b>1:15 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>6/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 3, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 5 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	



*Handwritten signature: J. L. Henry*

*[Faint, mostly illegible text from the reverse side of the page, appearing as bleed-through. Some words like "HOSPITAL", "LABORATORY", and "EXAMINATION" are partially visible.]*

CERTIFICATE OF DEATH

Reg. Dist. No. 07331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>10<sup>th</sup> Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>S.</u> Last <u>ELLIS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES F. SPICER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA LLOYD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Charles Ellis, Laurel, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1, 1961</u> , to <u>6/11, 1961</u> , that I last saw the deceased alive on <u>6/11, 1961</u> , and that death occurred at <u>12:15</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-11-61</u>	
PHYSICIAN'S NAME (Type) <u>William B. Ellis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oprockley Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Esham Jr. Georgetown Del.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

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7343

# CERTIFICATE OF DEATH

Reg. Dist. No. 07332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>all his life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hosp.</b>				d. STREET ADDRESS <b>420 Stewart Lpace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Noah</b>		First <b>Noah</b>		Middle <b>T.</b>		Last <b>Ellis</b>	
4. DATE OF DEATH Month <b>6</b> Day <b>3</b> Year <b>19 61</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 4, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Ellis</b>				14. MOTHER'S MAIDEN NAME <b>Annie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT Address <b>Mrs. Bessie Ellis, Salisbury, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/11</b> , 19 <b>61</b> , to <b>6/3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/3</b> , 19 <b>61</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Fred R. Gramse</b>		M.D. <b>Salisbury, Md.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Fred R. Gramse, M.D. 402 South Division St., Salisbury, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acre Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07333

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisey</u> Middle <u>Ennis</u> Last <u>Ennis</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charles Ennis, Tyaskin, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>mild diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/1/1958</u> to <u>death</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>6/27/1961</u> and that death occurred at <u>12M</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest M. Lamm</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E M LAMORE</u>		22d. ADDRESS <u>DELMAR, DEL.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Tyaskin, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Yessie, Bivalve, Md.</u>		25a. REC'D BY REGISTRAR <u>DEL 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		25c. DATE	

CENTRAL BANK OF INDIA

(M)

1. The Central Bank of India was established on 1st April 1935 under the Central Bank of India Act, 1934. It is the apex institution in the financial system of India and is responsible for the issue and management of the currency of the country.

2. The Central Bank of India is a public sector enterprise and is owned by the Government of India. It is a member of the International Monetary Fund (IMF) and the World Bank.

3. The Central Bank of India is responsible for the formulation and implementation of the monetary policy of the country. It also acts as the banker to the Government and the Reserve Bank of India.

4. The Central Bank of India has a wide network of branches and offices all over India. It also has branches in several foreign countries.

5. The Central Bank of India is a member of the Indian Council of World Affairs and the Indian Council of Economic Relations.

6. The Central Bank of India is a member of the International Chamber of Commerce (ICC) and the International Union of Pure and Applied Chemistry (IUPAC).

7. The Central Bank of India is a member of the International Labour Organization (ILO) and the International Labour Office (ILO).

8. The Central Bank of India is a member of the International Labour Office (ILO) and the International Labour Office (ILO).

9. The Central Bank of India is a member of the International Labour Office (ILO) and the International Labour Office (ILO).

10. The Central Bank of India is a member of the International Labour Office (ILO) and the International Labour Office (ILO).

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07334

7345

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Walnut street</b>		d. STREET ADDRESS <b>Nr Kings Church</b>	
3. NAME OF DECEASED (Type or print) First <b>GROVER</b> Middle <b>C.</b> Last <b>GERMAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1892</b>
9. AGE (In years lost birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James H. German</b>	
14. MOTHER'S MAIDEN NAME <b>Rdxx Rosa A. Lloyd</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>(If yes, give year or dates of service)</b>		17. INFORMANT <b>Beulah L. German, Hebron, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> DUE TO <b>atherosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Diabetes mellitus</b> DUE TO (b) <b>Diabetes mellitus</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 15, 1961</b> to <b>June 29, 1961</b> , that I last saw the deceased alive on <b>June 15, 1961</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Del.</b> DATE SIGNED <b>7/1/61</b>			
ACTUAL SIGNATURE <b>W. J. [Signature]</b>		M.D. <b>Laurel, Del.</b>	
PHYSICIAN'S NAME (Type) <b>W. J. [Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>nr. Laurel, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>311 S. Main St. Federalsburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES M. JONES		JAN 15 1968	
AGE		SEX	
45		M	
RACE		EDUCATION	
W		H	
OCCUPATION		MANNER OF DEATH	
C		N	
PLACE OF DEATH		CITY	
H		B	
CITY		STATE	
B		M	
COUNTRY		ZIP CODE	
U		21201	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15 1923		H	
CITY		STATE	
B		M	
COUNTRY		ZIP CODE	
U		21201	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1968		H	
CITY		STATE	
B		M	
COUNTRY		ZIP CODE	
U		21201	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15 1923		H	
CITY		STATE	
B		M	
COUNTRY		ZIP CODE	
U		21201	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1968		H	
CITY		STATE	
B		M	
COUNTRY		ZIP CODE	
U		21201	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7346

07335

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Salisbury (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 (Union)</b>				d. STREET ADDRESS <b>R.D.# 1 (Union)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WILLIAM</b> Last <b>GRAVENOR</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>22ND</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 8, 1902</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Wico mico Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Ernest G. Gravenor</b>				14. MOTHER'S MAIDEN NAME <b>Laura E. Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-12-6045</b>		17. INFORMANT <b>Mr. Norman F. Gravenor (Son) #67A Camden Ave. Ext. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Cerebral Hemorrhage</b> Sudden (b) <b>Hypertensive Cardio-Vascular Renal Disease</b> 3 years (c) <b>Hypertension - Bih. Int. Nephrosis</b> 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5:15 A.M.</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. Herbert Sembly</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Herbert Sembly</b>				22d. ADDRESS <b>409 E. Church St. Salisbury, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jun 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 26 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>			

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CERTIFICATE OF DEATH

1. Name of Deceased

2. Age

3. Sex

4. Date

5. Cause

6. Signature

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. at Pen Gen Hospital</b>		d. STREET ADDRESS <b>404 Priscilla St</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM LESTER HEARNE</b>		4. DATE OF DEATH <b>JUNE 1st 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1911</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor (Electrical)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hebron, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Herbert W. Hearne</b>		14. MOTHER'S MAIDEN NAME <b>Alice Layfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Margaret P. Hearne (Wife)</b>		Address <b>404 Priscilla St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4/20/1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) }		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl Royer</b>		DATE SIGNED <b>Jun. / 3 / 61</b>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		<b>407 Camden Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

FOR SALE  
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U.S. GOVERNMENT

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>12</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>728 Jackson St</b>				d. STREET ADDRESS <b>728 Jackson St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>SARAH</b> Middle <b>REBECCA</b> Last <b>HOBBS</b>				<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>30th</b> Year <b>19 61</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 16, 1875</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <b>0</b> Days <b>14</b></td> <td>Hours <b></b> Min. <b></b></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <b>0</b> Days <b>14</b>	Hours <b></b> Min. <b></b>
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months <b>0</b> Days <b>14</b>	Hours <b></b> Min. <b></b>												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wicomico Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						
<b>13. FATHER'S NAME</b> <b>James R. Carey</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Millie Shockley</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b></b>		<b>17. INFORMANT</b> <b>Mr. Irl Hobbs (Son)</b>		Address <b>Fruitland, Maryland</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Coronary artery occlusion</b> DUE TO (c) <b>Coronary artery sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs?</b> <b>4 hrs</b> <b>?</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		<b>20f. (City or town)</b> (County) (State) <b>N/A</b>						
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19 53</b> <b>to</b> <b>June 30, 19 61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>June 29, 19 61</b> , <b>and that death occurred at</b> <b>7:30</b> <b>M.</b> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>L.V. Sohler</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>June 30/1961</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. L.V. Sohler</b>				<b>22d. ADDRESS</b> <b>Delmar, Maryland</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>July 2, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fruitland Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Fruitland, Maryland</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>				<b>ADDRESS</b> <b>SALISBURY, MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 5 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>					

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TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

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<div style="display: flex; justify-content: space-between;"> <span>7349</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</span> <span>07338</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>				d. STREET ADDRESS <b>216 Maryland Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>ALMA LEONARD HOPKINS</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>JUNE 23rd 19 61</b>							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 2, 1888</b>		<b>9. AGE</b> (In years lost birthday) <b>72</b> yrs.		<b>IF UNDER 1 YEAR</b> <b>6</b> Months <b>21</b> Days <b>Hours</b> <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cambridge, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Asbury White</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Matilda Robertson</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mr. Raymond W. Hopkins (Husband)</b> <b>216 Maryland Ave. Salisbury, Maryland</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		<b>20f. (City or town)</b> <b>N/A</b>		(County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5-28 1958</b> <b>to</b> <b>6-22 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>6-22 1961</b> , <b>and that death occurred at</b> <b>6:00 P. M.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> 						<b>22b. DATE SIGNED</b> <b>Jun. 23/1961</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Andrew C. Mitchell</b>		<b>22d. ADDRESS</b> <b>Maryland Ave. Salisbury, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>Jun. 25, 61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>				<b>23d. LOCATION</b> (City, town, or county) (State) <b>Salisbury, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>						<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 26 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 	

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TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7350 CERTIFICATE OF DEATH 07339											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>31 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						d. STREET ADDRESS <b>19X-2</b>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>C.</b> Last <b>Horsey</b>						4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11, 1890</b>		9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
								IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Marion Station, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Horsey</b>						14. MOTHER'S MAIDEN NAME <b>Mallie Davis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Monnie Ward--Whittington Apts.--Main St. Crisfield, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>355X</b> DUE TO <b>Acute Myocardial Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>1 day</b> DUE TO (c) <b>1 day</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hereditary Chorea -</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> <b>p.m.</b>		Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 2</b> , 1961, to <b>June 3</b> , 1961, that (I) (we) last saw the deceased alive on <b>June 3</b> , 1961, and that death occurred at <b>9:10 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>						22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Marion Station, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

3837

1997, 1998, 1999

Handwritten: *Handwritten*

1992

Dr. J. H. Brown

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FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7351 07340

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>520 Church St.</b>	
3. NAME OF DECEASED (Type or print) <b>Ernest Elwood Johnson</b>		4. DATE OF DEATH <b>6-12-61</b> 19 <b>61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1909</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR <b>10</b> Months <b>10</b> Days	
11. BIRTHPLACE (State or foreign country) <b>Oak Hall Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles E. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Laura Trader</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>220-01-7907</b>	
17. INFORMANT <b>Hilda L. Johnson</b>		Address <b>Snow Hill, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic fibrosarcoma</b> DUE TO (b) <b>197.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		DATE SIGNED <b>6-13-61</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL JUNE 14-1961 BAPTIST CEMETERY Pocomoke, Md.</b>		22b. DATE THEREOF <b>6-13-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pocomoke Md.</b>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Henry H. Watson</b>		24a. REC'D BY REGISTRAR <b>June 16 '61</b>	
ADDRESS <b>Pocomoke Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Evans</b>	

MEDICAL CERTIFICATION

11

1

James M. Wilson, Treasurer  
of the American Baptist Cemetery  
107 Oak St. N.E.,  
Washington, D.C.  
1-11-01

Dear Sir:

I am writing to you to inform you that  
the American Baptist Cemetery  
has been organized and  
is now open for business.  
The cemetery is located  
at 107 Oak St. N.E.,  
Washington, D.C.  
and is open for business  
from 9 A.M. to 5 P.M.  
every day except Sunday  
and holidays.

Very truly yours,  
James M. Wilson,  
Treasurer.

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The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7352 CERTIFICATE OF DEATH 07341

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dames Quarter</b>		
c. LENGTH OF STAY IN 1b <b>844 days</b>			d. STREET ADDRESS <b>Locust St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Jones</b> Last <b>JOHNSON</b>			4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1961</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>Colored</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>October 12, 1886</b> 74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>?</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			17. INFORMANT <b>Virginia Burk East Road Salisbury Md.</b>		
16. SOCIAL SECURITY NO. <b>?</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, general and cerebral</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubiti, severe</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 16, 1959</b> to <b>June 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 9, 1961</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			22a. SIGNATURE <b>V. Juerman</b> M.D.		
22c. PHYSICIAN'S NAME (Type) <b>V. JUERMAN, M.D.</b>			22b. DATE SIGNED <b>6/9/61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>6/12/1961</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Dames Quarter</b>			23d. LOCATION (City, town or county) (State) <b>Dames Quarter Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton O. Stewart Salisbury Md.</b>			25a. REC'D BY REGISTRAR <b>JUN 16 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Carlton L. Fennell</b>					





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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7354

## CERTIFICATE OF DEATH

Reg. Dist. No. 07343

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Worcester</b> b. COUNTY <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>Ocean City Highway</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bivens C. King King</b>			4. DATE OF DEATH Month Day Year <b>June 13 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-1902</b>	9. AGE (In years last birthday) <b>59</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chicken Raiser</b>			11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elijah W. King</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Short</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>222-03-5652</b>		
			17. INFORMANT Address <b>Mrs Alice H. King, Gerlin, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5/17, 1961</b> , to <b>6/13, 1961</b> , that I last saw the deceased alive on <b>6/13, 1961</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>David J. Gilmore</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>		DATE SIGNED <b>6/14/61</b>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-16-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Georgetown, Delaware</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Eakins</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 19 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Pines</b>		

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with information obtained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES OF AMERICA

Worcester, Massachusetts

John C. ...  
John C. ...

John C. ...

John C. ...

USA

John C. ...

John C. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

7355

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07344

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>303 Gordy Rd</b>		d. STREET ADDRESS <b>303 Gordy Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>HUGO</b> Last <b>LIND</b> SR. <b>SR.</b>		<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>29th</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 28, 1915</b>
<b>9. AGE</b> (In years last birthday) <b>46</b> yrs.		<b>10. AGE</b> (In years last birthday) <b>46</b> yrs.	<b>11. AGE</b> (In years last birthday) <b>46</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Timber Buyer-J.I. Wells Co.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Portsmouth, Virginia</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>U S A</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Francis Hogo Lind</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Caroline Dobbins</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>1</b>	
<b>17. INFORMANT</b> <b>Mrs. 1. Eugenia Lind (Wife)</b> Address <b>303 Gordy Rd Salisbury, Maryland</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma of right lung - generalized metastases (abdominal and inguinal esp.)</b> DUE TO (b) <b>lung - generalized metastases (abdominal and inguinal esp.)</b> DUE TO (c) <b>lung - generalized metastases (abdominal and inguinal esp.)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>163X</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year <b>N/A</b> 19 <b>N/A</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
<b>20f. (City or town)</b> <b>N/A</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>7/1</b> , 19 <b>57</b> , to <b>death</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/28</b> 19 <b>61</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <b>Ernest M. Larmore</b> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>June 30 /1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Ernest M. Larmore</b>		<b>22d. ADDRESS</b> <b>Delmar, Delaware</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial July 1, 1961</b>		<b>23b. DATE THEREOF</b> <b>July 1, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Salisbury, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 7 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kenna</b>		<b>25c. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kenna</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7356

07345

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>HENRY</b> Last <b>LITTLETON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Littleton</b>		14. MOTHER'S MAIDEN NAME <b>Banna Mae Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>Mrs. Gladys L. Littleton (Wife) 223 Morris Drive Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X MESENTERIC THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RUPTURED ABDOMINAL ANEURYSM</b> DUE TO (c) <b>4 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month <b>N/A</b> Day <b>19</b> Year <b>1961</b> Hour <b>N/A</b> o. m. <b>N/A</b> p. m. <b>N/A</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/18/1961</b> to <b>6/12/1961</b> , that (I) (we) last saw the deceased alive on <b>6/12/1961</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John M. Bloxam, Jr.</b>		22b. DATE <b>June 15 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John M. Bloxam</b>		22d. ADDRESS <b>Medical Center - Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>-Jun. 17, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JUN 16 '61</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
signed by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7357

07346

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>104 W. Chestnut St.</b>			d. STREET ADDRESS <b>104 W. Chestnut St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Peter</b> First <b>Frank Livingston</b> Middle <b>Lost</b>			4. DATE OF DEATH Month <b>June 17.</b> Day <b>19</b> Year <b>61.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14. 1878.</b>		9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired Trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>	11. BIRTHPLACE (State or foreign country) <b>Wicomico County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Benjamin Peter Livingston</b>			14. MOTHER'S MAIDEN NAME <b>Martha Carey</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Annie B. Livingston (Wife)</b> <b>104 W. Chestnut St. Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Many years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>Hour a. m.</b> <b>6-15-1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-20-1961</b> to <b>6-17-1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>6-15-1961</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Paul G. Cayaves, M.D.</b>		22b. DATE SIGNED <b>June 19, 1961</b>	22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul G. Cayaves</b>		
22d. ADDRESS <b>222 N. Division St. Salisbury, Md.</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. PLACE OF INTERMENT, REMOVAL (Specify)	23b. DATE OF INTERMENT	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Buried</b>	<b>June 19, 1961.</b>	<b>Wicomico Mem. Park, Salisbury, Maryland.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co. Salisbury, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JUN 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

ord of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>6 Mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>312 Park Heights Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>312 Park Heights Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Virginia Miller Mathews</b>				4. DATE OF DEATH <b>6-9-61</b>				5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>8/31/1916</b> 9. AGE (In years last birthday) <b>44</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.N.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>				11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Henry K. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Jewell</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>093-16-8083</b> 17. INFORMANT <b>Mrs. Jessie J. Miller, 434 Druid Hill, City</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate poisoning</b> 970.2 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Deceased took overdose of sleeping pills.</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>6-9-61</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b> 20f. (City or town) <b>Salisbury</b> (County) <b>Wicom.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6-10-61</b>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>6/12/1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b> 22d. LOCATION (City, town, or country) <b>Salisbury, Maryland</b> (State)				23. FUNERAL DIRECTOR <b>Hill and Johnson</b> ADDRESS <b>Salisbury, Md.</b> 24a. REC'D BY REGISTRAR <b>JUN 14 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>							

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Accounting

Calgary

1111 11th Avenue S.W.

Calgary, Alberta

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Henry H. Miller

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## CERTIFICATE OF DEATH

Reg. Dist. No. 07348

7359

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILFRED SAMUEL McCARDELL</u>		4. DATE OF DEATH Month Day Year <u>June 1 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>FREDERICK, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADRIAN C. McCARDELL</u>		14. MOTHER'S MAIDEN NAME <u>ALAFRETTA STONGBRAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>MRS. W. S. McCARDELL</u>		Address <u>Berlin MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>approximately</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>61</u> to <u>June 1</u> , 19 <u>61</u> , that I lost sow the deceased alive on <u>June 1</u> , 19 <u>61</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Worcester</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-1-61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann R. Embrey</u>		ADDRESS <u>Berlin MD</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>
			24b. REGISTRAR'S SIGNATURE <u>Orthur S. Kraus</u>



1  
FOR STATE  
HEALTH DEPT.

TO THE STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 2 Film G291 6/26/61 iwk											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Kansas</b> Md.				b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Princess Anne</b>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>Thomas R Mitchell</b>				4. DATE OF DEATH Month Day Year <b>6-20-61 19</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 18, 1931</b>		9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Air Force U.S.A.F.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Air Force</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Russell Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Viola Hoffman</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes Air Force now</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs Frankie Mitchell</b>				Address <b>Wichita, Kansas</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6-21-61</b>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>6-23-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Princess Anne, Maryland</b>		22d. LOCATION (City, town, or country) (State) <b>Princess Anne, Maryland</b>			
23. FUNERAL DIRECTOR <b>Levin R. Wilson</b>				24a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

1943

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Benjamin General Hospital

Thomas R. Mitchell

Nov. 1, 1941

Mr. C. W. ...

General Hospital

Mr. C. W. ...

Donor's decision

Autistic-like heart disease

Mr. C. W. ...

Mr. C. W. ...



1

Mr. J. H. Smith

Albany, N. Y.

Dec. 15, 1892.

My dear Sir,

I have the honor to acknowledge the receipt of your letter of the 12th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours,  
J. H. Smith

Very truly,  
J. H. Smith

Dec. 15, 1892.

My dear Sir,

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and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

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I am, Sir, very respectfully,  
Yours,  
J. H. Smith

Very truly,  
J. H. Smith

Holloway & Co. Salisbury, Wiltshire.  
Selling from 21st. London Secretary  
21st. Salisbury, Wiltshire.  
Holloway & Co. Salisbury, Wiltshire.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301-W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
7362											
07351											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				d. STREET ADDRESS <b>535 Wailes Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Homer</b> First <b>Nickerson</b> Middle <b>Nickerson</b> Last <b>Nickerson</b>						4. DATE OF DEATH <b>June 9 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk. Retired Grocer) Unk.</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsville, Maryland</b>			11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		
13. FATHER'S NAME <b>Henry Nickerson</b>						14. MOTHER'S MAIDEN NAME <b>Emily Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>735P.M.</b>					
17. INFORMANT <b>Mrs. Dora V. Nickerson (Wife)</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> 10 yrs. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b>		20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/8/61</b> , 19 <b>61</b> , to <b>6/9/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/9/61</b> , 19 <b>61</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>Jun. 9/1961</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>						22d. ADDRESS <b>P. O. 671 -- Salisbury, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jun. 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b>		23e. REC'D BY REGISTRAR <b>JUN 15 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>											



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07352

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 Hebron Route</b>				d. STREET ADDRESS <b>R.D.# 1 Hebron</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>SILAS</b> Last <b>OWENS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>9th</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 15, 1882</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>		IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Quantico, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Cellious Owens</b>				14. MOTHER'S MAIDEN NAME <b>Maggie E. Goslee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Minnie P. Owens (Wife) R.D.#1 Hebron Quantico, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20-0 Hemorrhage, Cerebral Artery</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) <b>Arteriosclerotic Heart Dis</b> DUE TO (c) <b>10 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>27 May 1961 to 9 June 1961</b> that (I) (we) last saw the deceased alive on <b>7 June 1961</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George G. Schlesinger</b>				22b. DATE <b>June 10/1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Geo. G. Schlesinger</b>				22d. ADDRESS <b>Mardela, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 12, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Quantico Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Quantico, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JUN 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

DEPARTMENT OF HEALTH  
CENTRAL OFFICE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7364

## CERTIFICATE OF DEATH

07353

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>				d. STREET ADDRESS <b>530 Winder St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MORRIS</b> Middle <b>THOMAS</b> Last <b>PHILLIPS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>10th</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1878</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor &amp; Builder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
11. BIRTHPLACE (State or foreign country) <b>White Haven, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Estelle Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <b>Mrs. Mattie Owens Phillips (Wife)</b>				Address <b>530 Winder St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Pinal Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>				20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12-5-1955</b> to <b>6-10-1961</b> , that (I) (we) last saw the deceased alive on <b>6-5-1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip A. Insley</b>				22b. DATE <b>June 14/1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>				22d. ADDRESS <b>Main St. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>June 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
23d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>				23e. (State) <b>MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>JUN 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 7365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07354											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> <b>Sussex</b> b. COUNTY <b>Sussex</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selbyville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>Box 7</b>					
3. NAME OF DECEASED (Type or print) <b>Barbara Naomi Powell</b>						4. DATE OF DEATH <b>6-6-61</b> 19 <b>19</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>X</b>		8. DATE OF BIRTH <b>Oct. 2, 1956</b>		9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Selbyville Del.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>George Powell</b>				14. MOTHER'S MAJOR NAME <b>Mildred Lockwood</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT <b>George Powell, Selbyville, Del.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia: pneumonia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Third degree burns 40 % and second degree 15 days</b> (c) <b>25 % of body surface.</b> DUE TO cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>X</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child was one of group of small children in burning house.</b>							
20c. TIME OF INJURY Month, Day, Year <b>6 P.M. 5-22-61</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <b>X</b> <b>Home</b>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Berlin Worcester Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> <b>X</b> Inquiry <input checked="" type="checkbox"/> <b>X</b> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> <b>X</b> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6-8-61</b>			
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>X</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-8-61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Long's Cemetery</b>			
22d. LOCATION (City, town, or country) <b>Selbyville Del.</b>				22e. REC'D BY REGISTRAR <b>JUN 13 '61</b>				22f. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			
23. FUNERAL DIRECTOR <b>Henry H. Watson</b> ADDRESS <b>Pocomoke City, Md.</b>											

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23

(M)

Alameda

California

San Francisco General Hospital

San Francisco, California

Box 7

100-100000

USA

(1)

San Francisco, California

United States Bureau of Health  
25 of 1000000

There was one of group of small children in group

Berlin, Germany

X-100

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San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7366 CERTIFICATE OF DEATH 07353											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queenstown, Md.</b> d. STREET ADDRESS <b>17X-2</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>						c. LENGTH OF STAY IN lb <b>5 mo. 1 day</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>K.</b> Last <b>Pries</b>						4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Lancaster Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S X A</b>	
13. FATHER'S NAME <b>Unk</b>						14. MOTHER'S MAIDEN NAME <b>Unk</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT <b>Records: Hospital</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Melanoma</b> 178-9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis due to general arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>N/A</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b>		20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 9, 1961</b> , to <b>June 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 10, 1961</b> , and that death occurred at <b>9:10 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee Lawry</b>						M.D. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>June 11, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee Lawry, M.D.</b>						22d. ADDRESS <b>Salisbury, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lawn Croft Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Boothwyn, Pa.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>						ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

(M)

(I)

HOLLAND & COMPANY, BARRISTER AT LAW  
111 1/2 St. Louis, Mo.  
June 12, 1902

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,  
Yours very truly,

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

Wm. H. Holladay

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Wm. H. Holladay

Wm. H. Holladay

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
It is 8 From Birth cert. 6/26/61 iwk  
7367  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 07356

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Md</u> COUNTY <u>Salisbury</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>REID</u>		4. DATE OF DEATH Month Day Year <u>JUNE 21</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1961</u>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Orlie Reede</u>		14. MOTHER'S MAIDEN NAME <u>Phelia Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Orlie Reede</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Asystole</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (wt 1060gms.)</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/21</u> , 19 <u>61</u> , to <u>6/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/21</u> , 19 <u>61</u> , and that death occurred at <u>10:21</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C Koller</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>6/21/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks M. West</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Clarence L. Howard</u>	

2042.191XVI

CERTIFICATE OF DEATH

(M)  
(2)

1. Name of deceased William J. ...  
2. Age ...  
3. Sex ...  
4. Date of death ...  
5. Place of death ...  
6. Cause of death ...  
7. Signature of physician ...  
8. Signature of registrar ...  
9. Date of registration ...  
10. Place of registration ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

7368

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07357

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2 Wks.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sp. Hill Pr. Sana.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>1002 N. Division St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>JONES</b> Last <b>RICHARDSON, Sr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Gov.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elliott Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Anne Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Martha H. Richardson, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>199X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>PELO NEPHRITIS - BILATERAL</b> (c) <b>CARCINOMATOSIS - PELVIC - SIGNET CELL TYPE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APR. 1</b> 19 <b>61</b> , to <b>JUNE 13</b> 19 <b>61</b> , that (I) (the) last saw the deceased alive on <b>JUNE 13</b> 19 <b>61</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>William B. Long</b>		22b. DATE SIGNED <b>6-21-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Long</b>		22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-22-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

(M)

(L)

14-10-1952 - 15-10-1952  
15-10-1952 - 16-10-1952

William R. Gentry  
1000 N. 1st St.  
St. Paul, Minn.

7369

7369

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07358

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>606 E. Isabella St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>DAUGHERTY</b> Last <b>ROBERTSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>9th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1884</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR <b>6</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Auto Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bivalve, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Francis Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wesley Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Mrs. Alma Robertson (Wife)</b> Address <b>606 E. Isabella St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Causing Brain</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m. <b>N/A</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 30, 1961</b> to <b>June 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 8, 1961</b> , and that death occurred at <b>1:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Carrie Hearn</b> M.D.		22b. DATE SIGNED <b>June 9 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Carrie Hearn</b>		22d. ADDRESS <b>N. Division St. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jun. 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REGISTERED REGISTRAR <b>JUN 13 1961</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>William L. Hearn</b>	

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CERTIFICATE OF DEATH

1968

(M)

Location

Residence

For use Hospital

DEATH CERTIFICATE

Name

Address

City

State

Zip

Age

Sex

Marital Status

Occupation

Education

Religion

Signature

Date

Place



I

1  
TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

091

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7371 CERTIFICATE OF DEATH 07360											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>79 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b> <b>14X-2</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						d. STREET ADDRESS <b>—</b>					
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>M.</b> Last <b>Rutter</b>						4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 24, 1872</b>		9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William J. Rutter</b>						14. MOTHER'S MAIDEN NAME <b>Rollison (1st name unknown)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-10-4338</b>		17. INFORMANT Address <b>Hospital Records Salisbury, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1961</b> to <b>June 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 21, 1961</b> , and that death occurred at <b>12:39 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/21/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>						22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Galena Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>				ADDRESS <b>Still Pond, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Victor N. Kennedy</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7372

07361

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Since 8/9/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Bluff State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>-</b> Last <b>Schneider</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1881</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Schumaker</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Leffet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records of Pine Bluff State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X Pulmonary Tuberculosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 9</b> 19 <b>60</b> to <b>June 21</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>June 21</b> 19 <b>61</b> , and that death occurred at <b>5:23</b> A. M., from the causes and on the date stated above.							
22a. SIGNATURE <i>E. P. Ritchings</i>				22b. DATE <b>6/21/61</b>		22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings, M.D.</b>	
22d. ADDRESS <b>Salisbury, Maryland</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>June 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>H. Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Bladenburg Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Woodson</i>				25a. REC'D BY REGISTRAR DATE <b>JUN 27 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Farris</i>	

CERTIFICATE OF DEATH

1912

1. Name of deceased	2. Sex	3. Age	4. Date of death
5. Place of death	6. Cause of death	7. Signature of physician	8. Signature of registrar
9. Remarks			

*Handwritten signature and text at the bottom of the page.*

7373

CERTIFICATE OF DEATH

Reg. Dist. No. 07362

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>428 Druid Hill Ave.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Haskell</u> Last <u>Schweppe</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive Eng. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Schweppe</u>		14. MOTHER'S MAIDEN NAME <u>Eva Jewett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Emily Wilt Schweppe. Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary cirrhosis</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>08</u> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md. 67961</u>	
PHYSICIAN'S NAME (Type) <u>William H. Fisher</u>		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6-20-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>J. Wm. Lee Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07363

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Elizabeth Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>BRYAN</b> Last <b>SHERWOOD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16th</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1886</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Robert Bryan</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Glanding</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Margaret Wagner, Delmar, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Hypertension, essential. Generalized arteriosclerosis.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>5 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1961</b> to <b>June 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 2, 1961</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L.V. Sohler</b>				22b. DATE SIGNED <b>6-16-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>				22d. ADDRESS <b>Delmar, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-16-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>				23d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co - Delmar, Del.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 20 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

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DEPARTMENT OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7375

## CERTIFICATE OF DEATH

Item 14 Film 0289 6/29/61 mh

07364

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>3,550 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2939 Eastern Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Sommers</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-90</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Herman Sommers</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>216-072375</b>				16. SOCIAL SECURITY NO. <b>216-072375</b>			
17. INFORMANT <b>216-072375</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> DUE TO (b) <b>Bronchial Asthma</b> DUE TO (c) <b>Pulmonary emphysema</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Pulmonary emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1</b> , 19 <b>51</b> , to <b>6/20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>June 19</b> , 19 <b>61</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lee L. Lawry, M. D.</b>				22b. DATE SIGNED <b>6/20/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-23-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
23d. LOCATION (City, town or county) <b>Balto. Co. Md.</b>				23e. REC'D BY REGISTRAR <b>JUN 26 61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be examined in 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7376

## CERTIFICATE OF DEATH

07365

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WICOMICO</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>1108 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DEER'S HEAD STATE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hebron</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Edward - SPRADLEY</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>7</b> Year <b>1961</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1887</b>		<b>9. AGE</b> (In years last birthday) <b>74 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>?</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>?</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerosis, general</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>May 26, 1958</b> <b>to</b> <b>June 7, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>June 7, 1961</b> , <b>and that death occurred at</b> <b>11:25 A.M.</b> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>V. Juerman</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>6/9/61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>V. JUERMAN, M.D.</b>				<b>22d. ADDRESS</b> <b>Deer's Head State Hospital</b> <b>Salisbury, Maryland</b>					
<b>23. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <b>6-12-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prof. Med. School Baltimore, Md</b>		<b>23d. LOCATION</b> (City, town or county) (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE JUN 15 '61</b> <b>Cushing S. Hanna</b>					

TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

M

I

General thoracic

intercostal, general

Diaphragm reflex

June 1, 1915

June 1, 1915

June 1, 1915

Gen's Head Case No. 100  
Baltimore, Maryland

June 1, 1915

June 1, 1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

1

Page 4

7377  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07366

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury 1Yr. 10mos. 14Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East New Market</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>09x-2</b>	
3. NAME OF DECEASED (Type or print) <b>Lillian Mae Stanley</b>		4. DATE OF DEATH <b>June 17 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/1900</b>
9. AGE (In years last birthday) <b>60 59/ yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dom. Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dom. Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David Jones</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Humphreys</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-3835</b>	
17. INFORMANT <b>Hospital Records -- Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic gangrene</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 W 1 Y 1 Y</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic gen.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/3/59</b> 19 to <b>6/17/61</b> 19, that (I) (we) last saw the deceased alive on <b>6/17/61</b> 19, and that death occurred at <b>2: M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>7 25P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>P. O. Box 671, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Thompsontown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near East New Market, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Traxton</b>		25a. REC'D BY REGISTRAR <b>JUN 20 61</b>	
ADDRESS <b>for Federalburg, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Traxton</b>	

M

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 24 from request 7/3/61 jmk											
07367											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b> c. LENGTH OF STAY IN 1b <b>3 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>XXXX</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b> d. STREET ADDRESS <b>XX</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>EDGAR JAMES STEPHENSON</b>						4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1922</b>		9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurseryman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
13. FATHER'S NAME <b>George M. Stephenson</b>						14. MOTHER'S MAIDEN NAME <b>Elvine Bratten</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>World # 2 215-26-508</b>					
17. INFORMANT <b>Mr. George M. Stephenson</b>						Address <b>Pittsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis</b> DUE TO (c) <b></b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5-8-1961</b> to <b>6-26-61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-26-1961</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank Lewis</b>						M.D. <b></b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-27-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b></b>						22d. ADDRESS <b>Willards Md.</b>					
23a. BURIAL, CREMATION, REMOVED <b>Burial</b>				23b. DATE THEREOF <b>6/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>		23d. LOCATION (City, town or county) (State) <b>Pittsville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>watson &amp; whaley</b>						ADDRESS <b>Selbyville, Delaware</b>		25a. REC'D BY REGISTRAR <b>JUN 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

VR A15 (4)  
15M 9/60



7379  
CERTIFICATE OF DEATH

Reg. Dist. No. 07368

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Princess Anne, Md Rt #2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel STEVENSON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 28 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>II/20/1900</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employer</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>			
13. FATHER'S NAME <u>Smith Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Hargis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>			
INFORMANT <u>Lena Alford, Princess Anne, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-1-1961</u> to <u>6-28-1961</u> that I last saw the deceased alive on <u>6-28-1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Coley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-28-61</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Cottage Grove Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>3 '61</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(2)

William H. Jones, Jr., Clerk

San Jose

San Jose, California

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

Item #2, Film G290 7/10/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 07369

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>John B. PARSONS Home for Aged</u>		d. STREET ADDRESS <u>315 Maryland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>(NONE)</u> Last <u>TOADVINE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1866</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLINERY CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILLINERY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIDNEY TRADER</u>		14. MOTHER'S MAIDEN NAME <u>ARABELLA TWILLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Records</u>		Address <u>John B. PARSONS Home for Aged</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Thrombosis</u> DUE TO <u>3322X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SALISBURY, MD</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1944</u> to <u>6/30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>61</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>Salisbury Md.</u> DATE SIGNED <u>Fred R. Grooms</u> ACTUAL SIGNATURE <u>Fred R. Grooms</u> M.D. <u>Salisbury Md.</u> PHYSICIAN'S NAME (Type) <u>Fred R. Grooms</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/3/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Wallace</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOST: FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
RACE  
BIRTH DATE  
PLACE OF BIRTH  
MARRIED  
OCCUPATION  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR  
LOCAL HEALTH OFFICER

1. Name of deceased		2. Age		3. Sex		4. Race	
5. Birth date		6. Place of birth		7. Married		8. Occupation	
9. Cause of death		10. Place of death		11. Date of death		12. Time of death	
13. Signature of physician		14. Signature of registrar		15. Local health officer		16. Date of filing	

7381

## CERTIFICATE OF DEATH

Reg. Dist. No. 07370

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Route #1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE D. JONKINS</u>				4. DATE OF DEATH Month Day Year <u>June 9 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1878</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ROXANNA DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EZRA W. DICKERSON</u>				14. MOTHER'S MAIDEN NAME <u>LUCY ANN BRASURE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>No</u>		INFORMANT Address <u>Mrs. J. Howard McLaughlin</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE ESOPHAGEAL VARICES</u> DUE TO <u>462.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CIRRHOSIS LIVER</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/7/61</u> to <u>6/9/61</u> , that I last saw the deceased alive on <u>6/9/61</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Bloxom Jr.</u> M.D.				MEDICAL CENTER <u>6/10/1961</u>			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM JR.</u>				<u>SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/12/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Anne A. Burboye BERLIN MD</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

M

From the Bureau of Census  
Special Agent in Charge  
Washington, D.C.

See also

File

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7382

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07371

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2460 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Secretary</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>09X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>Sue</b> Last <b>Townsend</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/14/1878</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lambert Quillen</b>				14. MOTHER'S MAIDEN NAME <b>Ida Fickman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Carrie Lawrence, Secretary Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus; arteriosclerotic heart disease; arteriosclerosis, general</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>general</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 4</b> , 19 <b>54</b> , to <b>June 29</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>June 29</b> , 19 <b>61</b> , and that death occurred at <b>8:35 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. V. Maldve</b>				M.D. <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>6/30/61</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>7/2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION (City, town or county) (State) <b>East New Market, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth S. Melongby</b>				ADDRESS <b>E. N. Market</b>		25a. REC'D BY REGISTRAR <b>AUL 5 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



7383

CERTIFICATE OF DEATH

Reg. Dist. No. 07372

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> <u>P3X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Chincoteague</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Lee Watson</u>				4. DATE OF DEATH Month Day Year <u>6 17 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1, 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Maintenance man. Westinghouse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>David Watson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Taten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>191-14-5857</u>			
17. INFORMANT <u>Weatha Watson</u>				Address <u>Chincoteague</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma; left lung</u> 163X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/14/61</u> , 19 <u>61</u> , to <u>6/17/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/17/61</u> , 19 <u>61</u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred W. Grigoleit</u>				ADDRESS (Street, city or town, state) <u>Peninsula General Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Alfred W. GRIGOLEIT</u>				DATE SIGNED <u>6/17/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 20, 1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>John Taylor Memorial</u>				22d. LOCATION (City, town, or county) (State) <u>Temperanceville, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer</u>				ADDRESS <u>Chincoteague, Va.</u>			
24a. REC'D BY REGISTRAR <u>June 21 61</u>				24b. REGISTRAR'S SIGNATURE <u>William B. Salyer</u>			

STATION

CELESTIAL AIR OF DEATH

1883

(M)

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## CERTIFICATE OF DEATH

Reg. Dist. No.

07373

7384

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Locust St</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Whaley</u> Last <u>Whaley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1961</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>1</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert G. Whaley</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Whaley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>776X</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 955gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776X</u> DUE TO (c) <u>1 wk.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/26</u> , 19 <u>61</u> to <u>6/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/1</u> , 19 <u>61</u> , and that death occurred at <u>9:50</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Holls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>6/1/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 5, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fruitland</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart</u> ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be furnished by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07374

1. PLACE OF DEATH e. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>I Month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dames Quarter</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deers Head State Hospital</b>		d. STREET ADDRESS <b>Dames Quarter</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha Washington White</b>		4. DATE OF DEATH <b>6-22-61</b>		Month <b>6</b> Day <b>22</b> Year <b>61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-1-1882</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		13. FATHER'S NAME <b>John S. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Jane Laetherbury</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Herman Jones Princess Anne, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured right hip with infection</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arterio-sclerosis.</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home and fractured right hip.</b>					
20c. TIME OF INJURY Month, Day, Year <b>A.M. 5-26-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At home.</b>	
20f. (City or town) <b>Dames Quarter Somerset Md.</b>		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER		DATE SIGNED <b>6-23-61</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Macedonia</b>	
22d. LOCATION (City, town, or country) <b>Dames Quarter, Maryland</b>		(State)			
23. FUNERAL DIRECTOR <b>William H. James Jr. Princess Anne, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>					

MEDICAL CERTIFICATION

FOR WIFE  
FROM THE

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Alcoholic  
Bulimic

John H. H. H. H.

John H. H. H. H.

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Alcoholic-Bulimic

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Alcoholic-Bulimic

Alcoholic-Bulimic

Alcoholic-Bulimic

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7386											
07375											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>104 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b> d. STREET ADDRESS <b>415 S. Liberty Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Burton</b>			First Middle Last <b>Wicks</b>			4. DATE OF DEATH <b>June 5 19 61</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Church Janitor</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Buck Wicks</b>						14. MOTHER'S MAIDEN NAME <b>Agnes French</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-20-3958</b>		17. INFORMANT <b>James Little Centreville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recurrent cerebral vascular accident</b> DUE TO (c) <b>Arteriosclerosis, general</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>11 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Diabetes mellitus</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 21</b> , 19 <b>61</b> to <b>June 5</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>June 5</b> , 19 <b>61</b> , and that death occurred at <b>7:25 P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>V. Juerman</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/6/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>						22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cornwall Cem</b>				23d. LOCATION (City, town or county) (State) <b>Queenstown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Ashfield</b>						ADDRESS <b>Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07377

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>669 Fitzwater St.</b>		d. STREET ADDRESS <b>669 Fitzwater St.</b>	
3. NAME OF DECEASED (Type or print) <b>Philomena Evette Wright</b>		4. DATE OF DEATH <b>6-7-61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James P. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Clara Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clara Wright 669 Fitzwater St.</b>		Address <b>Salisbury Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>491X</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/26/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR <b>Clinton F. Stewart Funeral Home, Salisbury Md.</b>		24. REC'D BY REGISTRAR <b>Arthur S. House</b>	
24a. DATE <b>JUN 16 '61</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

Reg. Dist. No.

07378

7388

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 12 SPROUCE-DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEVERING THOMAS</u> First Middle Last <u>Young</u>				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-1896</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCK</u>		11. BIRTHPLACE (State or foreign country) <u>BLOXOM, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA JANE BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-07-1292</u>		INFORMANT <u>BEATRICE YOUNG-DELMAR</u> Address <u>MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1961</u> , to <u>June 22, 1961</u> , that I last saw the deceased alive on <u>June 22, 1961</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David L. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>June 22, 1961</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-B. Marvel Co - Delmar Del</u>				24a. REC'D BY REGISTRAR <u>JUN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

288

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

ROBERT YOUNG  
31-11-1900  
WHITE  
TRUCK DRIVER  
BROOKLYN, N.Y.  
15 JEROME ST. BROOKLYN, N.Y.  
1900

W. S. MONTGOMERY  
BUREAU OF VITAL STATISTICS  
JAN 22 1901

## CERTIFICATE OF DEATH

Reg. Dist. No.

07373

7389

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Rt#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BRIAN</u> Middle <u>SCOTT</u> Last <u>ZIARA</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/13/61 11:32 PM</u>		
9. AGE (In years lost birthday) yrs. <u>9</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>13</u>		11. IF UNDER 24 HRS. Hours <u>9</u> Min <u>13</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID ZIARA</u>				14. MOTHER'S MARDEN NAME <u>SANDRA SHIRK</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		INFORMANT <u>SM. DAVID ZIARA</u>		Address <u>SAME</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5 Respiratory obstruction, aspiration and atelectasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atelectasis.</u> (c) <u>Prematurity; Premature separation placenta.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>birth 6/13, 1961</u> to <u>6/14, 1961</u> , that I last saw the deceased alive on <u>6/14, 1961</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Ernest M. Larmor</u>			ADDRESS (Street, city or town, state) <u>Delmar, Del.</u>			DATE SIGNED <u>6-14-61</u>		
PHYSICIAN'S NAME (Type) <u>E. M. LARMORE</u>			<u>Delmar, Del.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co.</u>				ADDRESS <u>Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>		
						24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hume</u>		

hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTINELA DE MAR

5-1883

(M)

Winds

Barometer

Thermometer

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Latitude

Longitude

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Wind

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Direction

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